DDRS Policy Feedback Comments and Clarification

Policies Issued March 5, 2011

July 8, 2011

Contents

Advance Directives

I'm not understanding. Does this mean that the only individuals who receive Waiver services who can have advanced directives are the ones who are considered competent? Who makes the decision of competency? That is, if a client is emancipated but has autism and only a few words, is he considered competent for this situation? Does this mean that an individual with a guardian cannot have an advanced directive?

I haven't had this situation come up, but wanted to make sure I understood it if it did.

The individual has not been adjudicated incompetent. The policy has been changed to include legal guardian.

Besides family members and others named by law, what role would a guardian play in Advanced Directives? Primary providers many times have responsibilities for Health Care Coordination type of activities. How is this rolled into Advanced Directives' policies?

The guardian makes the decisions and has total control.

Definitions – Within the body of the policy the reference is to "trusted helper", but the definitions refer to "trusted other." May want to use only one of the terms.

Agree. Policy changed to "trusted other".

According to BQIS Bulletin #09 (originally distributed on 6/2/04 – see attached), "[e]ven in situations where an individual has a legal, signed "out of hospital" Do Not Resuscitate (DNR) order, staff should perform CPR because a DNR applies only to a "health care provider" who has "actual notice" of the DNR (IC 16-36-5-15). A "health care provider" is defined in IC 16-18-2-163(c) as (1) a licensed physician; (2) a registered nurse; (3) a licensed practical nurse; (4) an advanced practice midwife; (5) a licensed nurse midwife; (6) a paramedic; (7) an emergency medical technician; (8) an emergency medical technician- basic advanced; (9) an emergency medical technician-intermediate; or (10) a first responder, as defined under IC 16-18-2-131." Is this still applicable? If so, the policy should reflect this information by not requiring all entities to comply with advanced directives?

The DNR order is only one aspect of advanced directives. If you do not meet the definition of a health care provider and you know the individual has a DNR, you are still obligated to inform the responding health care provider of the individual's DNR.

Need clarification on page 2 item on the following statement: "All entities providing services to the individual shall comply with the advance directives the individual has put in place." We are instructed by medical professionals in CPR training that we are not to adhere to Advance Directives of do not resuscitate. We are not medical professionals and cannot make a medical decision. We are to provide CPR until a medical professional arrives and inform them of the DNR order. Please clarify what your statement means.

See above.

This draft indicates that all providers are to comply with any advance directives. Please consider that per Indiana Code 16-3-5-19 only certain types of health professionals are authorized to comply with a Do Not Resuscitate order. Prior communication from DDRS has indicated that direct care staff did not meet the qualifications of an individual to enforce a DNR order.

See above.

Health Care Coordination

We continue to work on Health Care Coordination. Policy will be forthcoming.

Mortality Review

Under subsection, "Provider internal review of death", the policy states that "[t]he deceased's primary service provider shall immediately following a death, initiate an internal review of the death." The policy states what this internal review needs to include, but fails to state when this reviewed must be completed. To be consistent and to ensure that such reviews are timely completed, the policy should state when this internal review by the primary service provider must be completed.

BQIS/DDRS identifies the appropriate timeframes and communicates to the provider.

Under subsection, "BQIS Morality Review Committee," this committee is required to meet and "develop[] recommendations following review and discussion of an individual's death." This policy, however, fails to state a timeline for when, after the individual's death, this committee needs to meet and when the committee needs to complete the required recommendations.

We don't want to prescribe a timeframe.

Finally, "Exhibit A" attached to this policy, entitled "Categorization of Death", defines which events surrounding a death require "expedited review". While the majority of unexpected deaths require expedited review, per this chart, there are eight (8) unexpected deaths which do not require expedited review. These eight (8) unexpected deaths should require expedited review, like the rest of the unexpected deaths.

This exhibit has been removed from the policy.

What does the term immediately mean for this policy? It seems that upon discovering a consumer who is dead that one would call 911 or the ambulance or the police first.

How many days are reasonable before all of the reports are filed, the interviews taken/given etc?

Obviously we want you to take the necessary steps (i.e. call 911) first, but the expectation is to call the case manager in a reasonable, timely manner. In other words, after the necessary steps that would normally be taken in an unfortunate situation of death have occurred, notify the case manager.

In general, how does this policy pertain to situations in which the death of an individual does not occur while the individual is directly receiving services (e.g. visiting with family, in the hospital, at school, etc…)? In those instances, why would the residential provider be responsible to notify the CM, BDDS District Office, etc…, particularly, if they aren't the first provider to learn of the individual's death?

The residential provider takes on certain responsibilities when agreeing to care for individuals in this vulnerable population. While this may seem like a burden to some providers, in order to provide a clear, organized process for all instances this is necessary. The hospital will not notify.

What type of provider/funding sources does this policy apply to?

All DDRS administered services (waiver, SGL, state funded).

There doesn't appear to be any reference to Exhibit "A" in the policy. What is it and how does it relate to the policy?

Exhibit A has been removed from the policy.

#5, p. 2 – What about statements from non-staff members, like family members, hospital staff, school staff, etc…? What authority does the RHS provider have to request/demand such statements? What if the non-staff member refuses?

The RHS provider has no authority; this was intended for provider staff only. This has been clarified in the policy.

#10, p. 2 – This seems to presume that the provider has done something wrong that requires corrective action. Could it be modified to include the phrase "if any"?

Agree. Change made to the policy.

BQIS Mortality Review Committee – Is it possible to add a requirement that aggregate data collected through mortality reviews is shared with the provider community for the purposes of sharing highlighting systemic issues, trends, and/or highlighting areas of high risk?

This has been, and is our intention moving forward. Not added to the policy.

Under the provider internal review of the client death the policy requires a narrative review of all documentation related to the client's care. Does this narrative review mean that a summary of all of these documents need to be created or can it be as simple as stating that the document was reviewed and listing any issues or concerns that were identified through that review?

A narrative of relevant info resulting in death has been added to the policy.

Additionally under this narrative review section it states that the provider should review the "case manager notes, when services included a case manager;" The provider currently would not have access to case manager notes is this going to be changing?

Removed from policy. The idea was to review the case notes Case Managers share regularly after meetings, etc. not the case notes in our computer system.

It indicates that the internal review is to include identification of all involved parties including "all staff assigned to work with the individual" and all staff present at the time of the death. Is there a time period for "all staff assigned to work with the individual? Is it all staff within the past 30 days etc? Similar language is used in obtaining statements from "all staff assigned to work with the individual" and clarification is sought there as well.

All staff who have worked with the individual in the last 30 days.

Pre-Post Transition Monitoring

Both the "BDDS Transition Pre-Post Monitoring Checklist" and the "Pre-Post Monitoring Deficiency Action Items" form referenced in this policy should be attached to this policy.

Agree. These are included as forms now.

It doesn't appear that changing Day Service providers is covered by this policy. It should be by at least the Service Coordinator.

This has been added under the Detailed Policy Statement, 1c.

#3, p. 1, Detailed Policy Statement – Would the term "each action" include those actions involving non-waiver services? If so, why would a case manager be required to document the action?

This policy states that it is for Supported Living, which is a waiver setting.

Individual Specific Risk Management

We continue to work on Individual Specific Risk Management. Policy will be forthcoming.

Transition Activities

We continue to work on Transition Activities. Policy will be forthcoming.